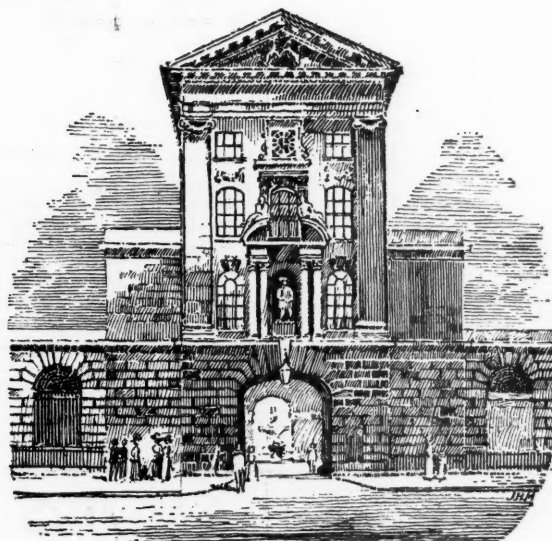


AUG 23 1929

ST BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXVI.—No. II.

AUGUST, 1929.

[PRICE NINEPENCE.]

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"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXXVI.—No. 11.]

AUGUST 1ST, 1929.

PRICE NINEPENCE.

CALENDAR.

- Fri., Aug. 2.—Prof. Fraser and Prof. Gask on duty.
Mon., „ 5—Bank Holiday.
Tues., „ 6.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Fri., „ 9.—Sir Percival Hartley and Mr. L. B. Rawling on duty.
Tues., „ 13.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
Fri., „ 16.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Sat., „ 17.—Tennis Match *v.* Winchmore Hill. Home.
Sun., „ 18.—Tennis Match *v.* Bank of England Away.
Mon., „ 19.—**Last day for receiving matter for the September issue of the Journal.**
Tues., „ 20.—Prof. Fraser and Prof. Gask on duty.
Fri., „ 23.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Tues., „ 27.—Sir Percival Hartley and Mr. L. B. Rawling on duty.
Fri., „ 30.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.

EDITORIAL.

FOR thirty-six years the JOURNAL has greeted the world with an outer garment of the same pattern. Never a thing of beauty, except perhaps in the brain of its designer, it has served the dual purpose of protecting the contents, and of whetting the reader's appetite for the joys within. And now the critics have begun their miserable task of unsettling our fixed convictions, so that we are forced to look at the thing again. What we have praised as simplicity must now be called plainness; when we boasted that the

design struck the right note of informality, we should have deplored its lack of dignity. Thus horribly has old Use-and-Wont deceived us. Filled with misgiving we put the matter in the hands of our readers.

The points on which we ask for criticism—and may it be constructive, suggestive criticism—are firstly whether the cover design should be altered, whether there should be a coloured cover, and whether it should be on stiff paper; secondly, whether a smaller, more convenient size (height and depth) of the JOURNAL should be adopted.

The present paper and the high standard of our matter we propose to leave unchanged.

* * *

Dr. Hugh Thursfield has retired from the active staff of the Hospital.

Several circumstances have combined to suggest that such an event would be for him a distant one. The laws of chance have decreed that his promotion to the office of full Physician should have been comparatively recent; the hand of time has weighed lightly upon his shoulders and upon his mind, so that the fresh charm and kindness of his personality have made him a friend to those divided from him by years. It is to be hoped that his departure from the active staff will not produce too great a severance.

He is to be congratulated on two achievements that mark his departure, the first being one with which his name is long likely to be associated. He has helped into being the plans for a complete children's department, with its definite staff, organization and wards. He has seen into a new edition a text-book of children's diseases second to none in value. It may be perhaps some slight consolation, in any retirement, to feel that it has been made while the powers of achievement still remain undimmed in lustre.

He may be sure that his juniors at Bart.'s, perhaps especially his protégés from Oxford, wish him "au revoir" with regret and with affection.

* * *

We extend a hearty welcome to Prof. H. H. Woollard, M.D., B.S.(Melbourne), who has been appointed to the University Chair of Anatomy tenable at St. Bartholomew's.

* * *

We are not acquainted with the method by which the acting chiefs of the Surgical Unit are selected, but it is certain that there could have been no happier choice than that of Prof. Grey Turner, who was at Bart.'s from June 10th to June 22nd. Perhaps his most striking characteristics are his energy and a breadth of interest in surgery, which carries him through the whole length of surgical history and through the whole gamut of surgical experience. For everything from the age of flint knives to the age of radium, from the radical cure of a hernia to the Talma-Morison operation, he shows the same serious and critical enthusiasm. His operative technique is impressive, not for any dramatic quality, but for the quiet orderliness which suffers no hitch in the theatre, nor, we learn, in the ward afterwards. The one complaint we have to make is that he has a greater knowledge of the history of the Hospital than most of us possess, a knowledge, moreover, which he was able to use with great effect on his teaching rounds.

We take this opportunity of welcoming Prof. Grey Turner as a Perpetual Student of St. Bartholomew's.

* * *

The victory of the Hospital water polo team must not be left unsung. By defeating Guy's in the final of the inter-hospital competition after a triumphal progress through the earlier heats, they not only introduce the cup to Bart.'s, but take it from Guy's for the first time in history. We couple with our congratulations the hope that the Cup will long remain in its new home.

* * *

ST. BARTHOLOMEW'S HOSPITAL WOMEN'S GUILD.

We are greatly indebted to the Terrell String Quartette—of which two of the Misses Bowlby are members—for a delightful concert which they gave for our funds at the Court House, Marylebone Lane, on June 4th, at

8.15. The Hall was quite filled by a large and enthusiastic audience, for whom a delightful evening's music was provided. The artistes are not only to be greatly congratulated on the very finished performance which they gave, but also upon the selection of the various items, both from an artistic and a musical point of view. We would specially like to take this opportunity of recording our gratitude to both organizers and performers of the Terrell String Quartette, and of thanking them at the same time very much for a most acceptable gift of £38 2s. which they sent to our funds as the result of their concert.

Again, for the third year, we have great pleasure in announcing the very successful result of our Provision Stall held at the Hospital Garden Fête on June 13th, 14th and 15th. This year it was most efficiently and capably organized by one of the members of our Executive Committee, Mrs. Price, and to her and her many helpers we owe a great debt of gratitude for the energy with which they carried it through. They are especially to be congratulated as, in spite of the indifferent weather on the second day, which must have deterred many possible purchasers from attending, a most encouraging total of £140 was realized.

MORE MEDICAL NOTES.

By Sir THOMAS HORDER, Bt.

ON SOME DRUGS.

(1) Medicines are given in routine fashion "three times a day" mainly for convenience and in relation to the chief meals. In all acute diseases, and when patients are gravely ill, this instruction is inappropriate. The "sign" should then be "every four (or two or six, etc.) hours." For example, a patient suffering from pneumonia needs his medicines, not less, but perhaps more, by night than by day.

(2) The young doctor is perhaps too free with stimulants, and the old doctor is perhaps too free with sedatives, in treating elderly patients.

(3) In prescribing for a neurasthenic patient, if in doubt whether to choose a stimulant or a sedative, choose a sedative.

(4) For most new laxatives the claims are made that they "assist Nature," and that they "are not really drugs." Gradually they make unholy, yet very helpful, alliances with the pharmacopœia of unrighteousness. The new claims made for the hybrid preparations are greater than before, because it is conveniently forgotten to shed any of the old ones.

(5) In obscure pyrexia certain drugs are sometimes of diagnostic value: quinine in malaria, salicylates in acute rheumatism, emetine in amœbic dysentery, alkalis in bacilluria, arsenic in rat-bite fever, and santalin in *Ascaris lumbricoides*.

(6) To give "double the dose" of sodium bicarbonate with sodium salicylate in the treatment of rheumatic fever, though its assigned purpose is the prevention of gastric irritation and constipation, is probably a survival of the older method of treating this disease by large doses of alkalis.

(7) The use of sodium bicarbonate in acid dyspepsia is often disallowed on theoretical grounds, because it leads to the production of carbon dioxide gas. "My doctor won't let me take bicarbonate of soda, though it is the only thing that does me good." Why deny the patient the satisfaction of "bringing up the wind"?

(8) Ordering "stimulant expectorants," such as ammonium carbonate, in the early days of pneumonia and of acute bronchitis, displays an odd lack of thought. For there is, as yet, no secretion present, and to increase the vascularity of the bronchial mucosa serves no useful purpose. What does result, however, is that the painful and purposeless cough becomes still more so.

(9) Whatever theoretical indications against the use of the drug may seem to be present, no patient suffering from failing heart should be denied the possible help to be given by digitalis.

(10) If no benefit follows the use of digitalis in failing heart, the drug should never be discontinued until it is certain that the dose has been increased to an amount which is just below the level of toxic effects.

(11) We are told that strychnine does not help a failing heart. Let us say, then, that it helps a failing pulse.

(12) When strychnine is prescribed as a tonic it is well to omit the evening dose, as this sometimes tends to prevent sleep. The same remark applies to nux vomica, which is a frequent cause of restless nights.

ON SOME FRACTURES OF THE TIBIA AND FIBULA: WITH NOTES OF FIVE CASES.



THE subject of fractures is one which usually only appeals with interest to a minority. A study of fractures of the leg, however, based on the records of five consecutive cases, which in variety cover all the best-known types of fracture of the tibia and fibula, is probably a matter of more general interest. Moreover, as the histories have been followed throughout almost the whole period of convalescence, a critical survey of methods of treatment and their immediate results is possible. In none of these cases, however, is the injury sufficiently remote to assess the presence or the amount of any permanent disability.

The cases fall roughly into three groups:

- A. Fracture of the upper end.
- B. Fractures of the shaft.
- C. Fracture-dislocations of the ankle-joint.

All X-rays are reproduced as simplified line drawings traced directly from the negatives, except those of Case 5, which are drawn from lantern-slides.

A. Fracture of the Upper End of the Tibia and Fibula.

CASE I:

O. J., æt. 57; dairy shop keeper.

16.iii.29: Fell down-stairs with leg doubled up under him. After the accident felt great pain in the leg and could not use it.

On examination.—Local condition: Whole of upper third of leg swollen and œdematous; deformity of upper part of leg with abnormal motility, eliciting crepitus.

General condition: Slight shock; alcoholic aroma; oral sepsis ++. Leg placed in Neville's splint, with side-pieces for the night pending X-ray.

17.iii.29: X-ray (Case 1, A and B): Extensive oblique fracture of upper third of tibia involving the tuberosity. Fracture of fibula at (a) upper end, (b) lower third. There was now very considerable œdema of almost the whole length, extensive fracture blisters, and it was therefore decided to sling the limb in a Thomas's knee-splint, and apply continuous traction. Under anæsthesia the limb was placed in the splint and a Pearson caliper applied to the malleoli. Fixed traction was employed. X-ray (Case 1, C) showed that the caliper had been applied too low and the inner point allowed to penetrate too far into the cancellous bone. The correct points for application of the caliper are indicated by the arrows, i.e. $\frac{1}{2}$ in. above the malleoli.

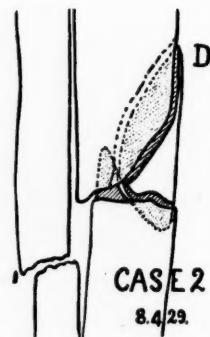
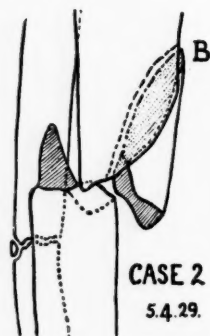
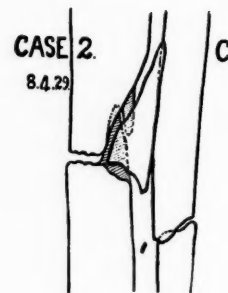
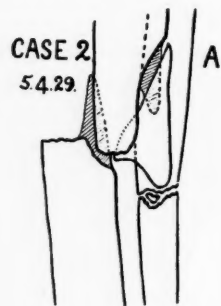
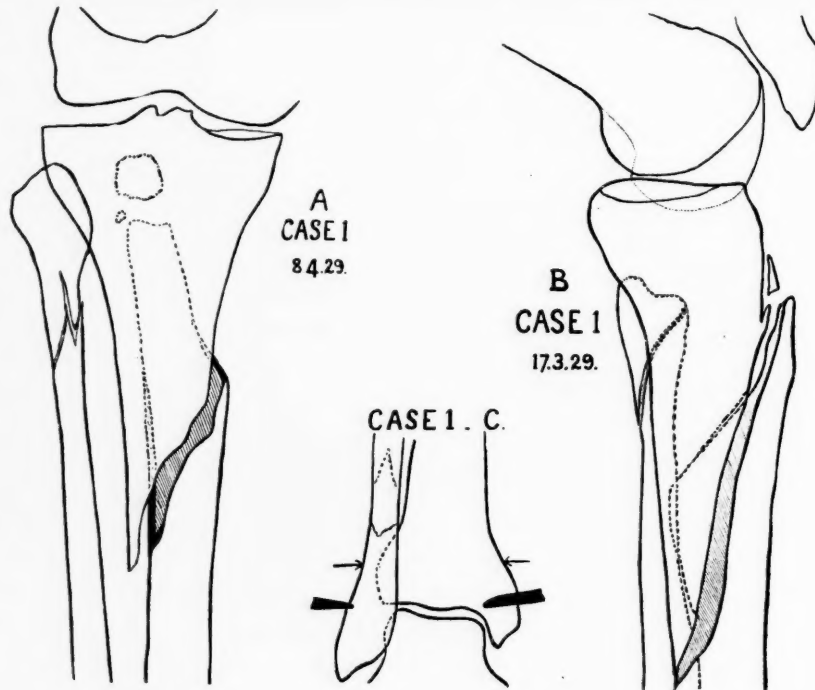
20-25.iii.29: Delirium tremens. Recovered with appropriate homœopathic treatment.

8.iv.29 (three weeks from injury): Splint and caliper removed. X-ray showed position not to have altered and signs of callus formation, although clinically there was very little evidence of union. A full plaster was applied from mid-thigh to toes with windows for the caliper wounds. Left hospital 14.iv.29 (four weeks from injury).

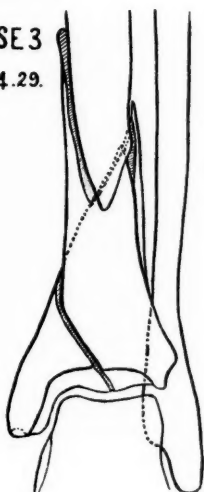
29.v.29 (ten weeks): Plaster removed; firm union; light plaster from mid-thigh to mid-calf.

12.vi.29: Plaster removed. Good union clinically. Knee flexion through 60°; considerable œdema of ankle and leg. Dorsi-flexion of ankle nearly full; plantar flexion half way. Massage begun. Walking begun with valgus wedge.

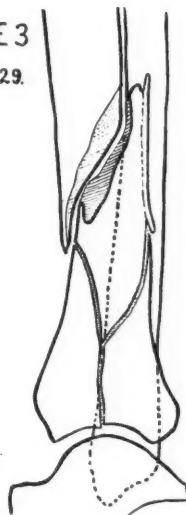
9.vii.29 (sixteen weeks after injury): Less œdema of leg, still some at ankle. Knee flexion to 90°. Some pain in knee at night. Walks easily with occasional support from a single stick.



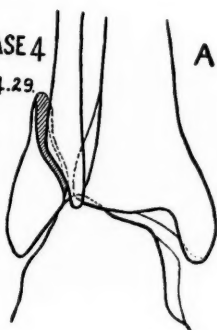
CASE 3
4.4.29.



CASE 3
4.4.29.

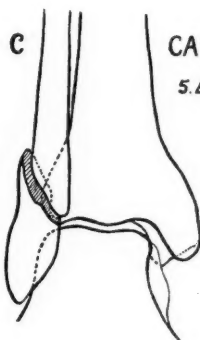


CASE 4
4.4.29.



A

CASE 4
5.4.29.

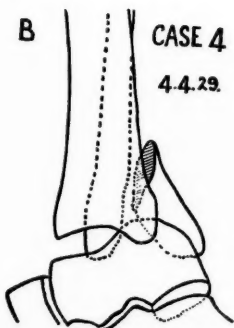


C

CASE 5
18.3.29.

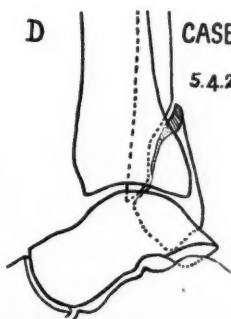


CASE 4
4.4.29.



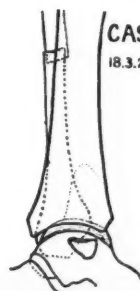
B

CASE 4
5.4.29.



D

CASE 5
18.3.29.



This fracture is of an unusual type, especially in that it involved the tuberosity of the tibia. In spite of this the patient has got moderately good function of the knee-joint. A full plaster was kept on until twelve weeks after the injury because (a) damage to the bone was considerable, (b) very little consolidation was evident when the plaster was first applied, and (c) the patient was of heavy build, and his more than occasional unsteadiness (of bacchanalian origin) had to be taken into account.

Caliper extension on a Thomas splint was quite successful in maintaining the position of the fragments, in spite of the fact that in the stage of delirium the traction cord carried away, and one point of the caliper became entirely detached from the fibula for some hours.

B. Fractures of the Shaft of Tibia and Fibula.

CASE 2.—Transverse fracture.

R. C—, æt. 41; fitter's mate.

5.iv.29: While helping to shift a 15-cwt. flat iron casting set edgeways, it became unbalanced and fell sideways, striking patient in middle of left leg. Unable to use leg after accident.

On examination.—Local condition: Bruising and swelling of middle two-thirds of leg—not severe; obvious deformity, and the ends of the fragments of tibia could be readily felt beneath the skin; lower fragment displaced inwards. General condition good; slight oral sepsis.

5.iv.29: X-ray (Case 2, A and B): Comminuted transverse fracture of tibia and fibula about junction of middle and lower thirds; lower fragment of tibia displaced inwards and backwards.

6.iv.29: Manipulated under anaesthesia, and leg placed in Neville's splint and side-pieces and slung in a cradle.

8.iv.29: X-ray (Case 2, c and d). Position good.

27.iv.29 (three weeks after injury): Splint removed; bruising subsided; full plaster case from mid-thigh to toes. Left hospital 29.iv.29 (three and a half weeks from accident).

21.v.29: X-ray. Slight angulation of tibial fragments; concavity forwards; no displacement; no lateral angulation.

12.vi.29 (ten weeks from injury): Plaster removed; good union clinically. Practically no movement at ankle-joint; swelling of ankle. Delbet's ambulatory plaster applied.

26.vi.29: Walking in Delbet, which is comfortable, but rather loose.

17.vii.29: Delbet removed; firm union; no pain; slight valgus. To wear valgus wedge.

It is unfortunate that a shift in position should have taken place between the time of reduction and when an X-ray was taken (while in plaster) six weeks later.

It is probable that this took place while patient was on the Neville's splint or at the time of application of the plaster. In spite of this, however, and also the fact that the transverse type of fracture is often very slow in healing, he has got good union. By means of the Delbet plaster he is able to walk about, taking weight through the fracture; but this apparatus effectively checks any tendency for bending to occur at the site of fracture, and is much more economical than a moulded leather splint, which is sometimes employed for the same purpose.

CASE 3.—Oblique fracture of the tibial shaft.

A. J—, æt. 52; secretary, C.L.B.

3.iv.29: While working at the top of a step-ladder patient fell, wedging his right leg between two of the steps; he felt his leg "go" and heard bones grating on one another. Did not attempt use of leg.

On examination.—Local condition: Swelling and œdema of lower third of right leg; no deformity; pain on any attempt at movement. General condition: *Nil ad rem.*

4.iv.29: X-ray (Case 3). Spiral fracture of tibia extending into ankle-joint; slight angulation, concavity forwards. Fibula intact.

Manipulation to attempt to correct angulation, and application of full plaster from mid-thigh to toes—no anaesthesia.

6.iv.29: X-ray. No material change in position.

8.iv.29: Left hospital (five days after injury).

15.v.29: X-ray (through plaster): Not much evidence of callus.

30.v.29: Heavy fall in plaster. X-ray: Position unaltered.

20.vi.29: (eleven weeks after injury): Plaster removed. Union firm; swelling of leg and ankle, and only slight movement at ankle. No further splinting; massage begun.

17.vii.29: Walking comfortably; no pain; going to take charge of a boys' camp.

This is a typical example of the spiral type of fracture, usually produced by indirect violence. In this case, in addition, the fracture extended sufficiently to involve the ankle-joint. Displacement was slight, the condition of the skin good, so there was no bar to the application of an immediate plaster, which has given quite a good result. The extensive fissures give large areas for the production of callus, so that consolidation is fairly rapid, in contrast to the transverse type (Case 2), where, in the absence of comminution, the area involved in the production of callus is the least possible. Moreover, young callus in an oblique fracture is, on account of its greater mass, better able to resist all, except compression, strains than callus of a similar type in the transverse fracture. In a transverse fracture it is not the mere transmission of weight that tends to produce bending, but rather the activity of the muscles (*e.g.* in walking) acting from the opposite ends of the bone that tend to produce or increase angulation at the site of fracture.

There is no intention here of discussing operative treatment, but in cases of this oblique type, if there is any considerable degree of angulation or separation of the fragments, an operation for securing the correct apposition by mechanical means, *e.g.* Parham's bands, would probably yield the earliest and most successful result.

c. Fracture Dislocation of the Ankle-joint.

CASE 4.—Pott's fracture.

J. Y—, æt. 57; builder's labourer.

4.iv.29: While wheeling a barrow was struck from behind by a car, his right leg being twisted behind him as he was knocked down.

On examination.—Local condition: Much swelling and deformity of right ankle, which was displaced backwards and outwards, and slightly everted.

General condition: Shocked; oral sepsis +; lacerated wound 4 in. long on inner side of lower third of right thigh.

4.iv.29: X-ray (Case 4, A and B). Fracture of lower end of fibula; tarsus dislocated backwards and outwards, with tilting outwards of astragalus; internal malleolus intact.

4.iv.29: Under anaesthesia: (a) Wound in thigh excised and sutured; (b) deformity of ankle corrected. Neville's splint and side-pieces applied for, *re* X-ray.

5.iv.29: X-ray (Case 4, c and d). Backward displacement and outward tilting of astragalus completely reduced; outward displacement of astragalus nearly so.

6.iv.29: Further manipulation under anaesthesia to attempt to complete reduction of outward displacement of astragalus. Plates applied from below knee to toes with foot inverted. Further X-ray showed no appreciable alteration after this manipulation. Patient was kept in hospital till 29.iv.29 for treatment of laceration—plaster remaining unaltered.

15.v.29 (six weeks after injury): Plaster removed; moderate swelling around ankle. Ankle dorsiflexion to 90°, 15° free movement. To walk with crutches and a valgus wedge. Massage begun 29.v.29 (eight weeks after injury).

12.vi.29: Walking comfortably; movements of ankle good. Dorsiflexion to 80°.

10.vii.29 (fourteen weeks after injury): Movements good; no pain; walks unaided; going to start work.

This case differs only from the classical Pott's fracture in that the internal lateral ligament was torn instead of the more usual fracture through the internal malleolus. The good result obtained is no doubt due in large measure to the completeness of correction of the posterior dislocation and the lateral tilting. If the weight-bearing mechanism (*i.e.* inferior surface of tibia and superior surface of astragalus) is correctly aligned in the sagittal plane the fibula and internal malleolus and ligaments can consolidate well on either side, as no strain is thrown upon them. If, however, there is an appreciable degree of lateral displacement and for tilting of the astragalus, then weight-bearing throws an undue strain on the internal malleolus and internal lateral ligament, causing these structures to be impeded and stretched in their process of repair, with consequent pain on the inner side of the ankle and valgus deformity, to which pes planus and general disorganization of the mechanism of the foot must be the inevitable sequels.

CASE 5.—Dupuytren's fracture.

G. I—, *æt.* 39; newsagent's carman.

18.iii.29: While helping to load a van the horse slipped and fell, so that the shaft of the van fell on to and crushed patient's right foot. Unable to walk after accident on account of great pain.

On examination.—Local condition: Considerable deformity above ankle-joint with displacement of foot outwards and eversion. Considerable swelling in region of internal malleolus. Two small abrasions above site of bony injury on outer side of leg.

General condition: *Nil ad rem.*

Admitted slung in Thomas splint pending X-ray.

18.iii.29: X-ray (Case 5). Fracture of internal malleolus and vertical fracture through tibia on outer side. Fracture of lower third of fibula with dislocation outwards and upwards of astragalus between tibia and fibula, and eversion of the tarsus.

19.iii.29: Under general anaesthesia foot was manipulated into a position of slight inversion and retained by the application of two plaster slabs to outer and posterior aspects of foot and leg, and bound in position by bandages.

20.iii.29: X-ray. Outward displacement of astragalus completely corrected; vertical fracture of tibia barely visible; internal malleolus still slightly displaced outwards.

7.iv.29: Plaster slabs replaced by plaster from mid-thigh to toes, split laterally; anterior portion removed daily to allow slight

voluntary dorsiflexion of ankle and toes. Left hospital 10.iv.29 (three weeks after injury).

24.iv.29 (five weeks after injury): Massage to leg and movements of knee and ankle begun. No weight-bearing; foot swollen; range of movement very small; pain over internal malleolus.

1.v.29: Plaster cut down to below knee.

8.v.29: Weight-bearing begun; split plaster gradually left off. About 15° of movement in ankle joint.

22.v.29 (nine weeks after injury): Walking with a valgus wedge begun; dorsiflexion much limited by pain; ankle was manipulated under gas on 6.vi.29, a good range of movement being obtained with breaking of some adhesions.

28.vi.29: Less pain; movements of ankle increasing.

17.vii.29 (seventeen weeks after injury): Fair range of movement in ankle; can walk unaided, but lacks confidence; ankle a good shape; still a little pain. Going to convalescent home.

Convalescence in this case has been somewhat protracted, but the injury was a severe one and caused very considerable disorganization of the ankle-joint. However, all of the cases here quoted have required about twelve weeks for complete restoration of function, so this case has not been unduly slow. In this connection it may be pointed out that the complete return of function in fractures of the tibia and fibula usually takes longer to come about than is commonly stated in text-books, though it is true that the patients can walk, but with a stick and with considerable lameness, a month earlier than this.

In connection with this case it is interesting to recall Dupuytren's own description of the fracture, which appeared in his *Leçons Orales*, a volume of which was published by the Sydenham Society in 1847, and from which the following quotation is taken.

Speaking of "Species and Varieties of, and Complications and Casualties attending, Fracture of the Fibula," he says:

"Case XVI.—Fracture of the fibula and rupture of ligaments with dislocation of the foot outwards and upwards.

"C. N. Guilleman, a joiner, aged 54, of sanguine temperament, was coming half drunk out of a pot house, for the purpose of making water, when, reeling along in a hurried manner, he came to an inclined and slippery piece of ground, where he fell, his right leg being extended outwards from the body, the weight of which it had to sustain with the superadded momentum of the fall. Being unable to walk he was immediately conveyed to the Hotel Dieu. This occurred in the winter of 1816.

"When admitted, the presence of the usual signs of fractured fibula were readily detected; but what most attracted attention was the shortness of the leg, together with the almost doubled interval comprised between the malleoli, and the prolongation of the tibia downwards to a level with the sole of the foot; the astragalus and outer malleolus, with the whole foot, were drawn up on the outer side of the tibia, two inches above their normal

position. All these signs left no doubt that the ligaments connecting the tibia and fibula were torn through, and that the foot was dislocated outwards and upwards, carrying with it the outer malleolus."

General Conclusions.

All authorities are agreed that the first step in the treatment of a fracture should be the effective reposition of the fragments, so that, when union occurs, the mechanism of the affected bones and joints may be as little as possible altered.

The ultimate functional result is largely measurable in terms of the success or otherwise of immediate anatomical correction of the injury.

In all the cases described reduction of the fracture was carried out with a considerable degree of accuracy, so that the results are very satisfactory—though by no means perfect.

The next problem, namely, that of retaining the fragments in their corrected positions, is one on which many varying opinions have been expressed, and for the solution of which many different means have been devised. There are certain types of fracture (such as Case 1) and also open fractures, for which a Thomas splint combined with some form of traction undoubtedly provides the best method of treatment.

In simple fractures of the shaft and in fracture dislocations of the ankle-joint, however, one of two plans of treatment is usually advocated.

The first plan is to immobilize the limb on some well-known type of fixation splint, *e.g.* Neville, Dupuytren, Macintyre, etc., for two to three weeks while the process of union is initiated, and then to apply a split plaster in which the patient walks with the aid of crutches until union is sufficiently strong to allow of weight-bearing.

Massage and in some cases movements are begun at this stage or even earlier.

Alternatively, the retentive splint is kept on longer, and this is followed by a period during which the limb lies at rest in bed unsplinted until it is thought to be able gradually to take the strain of the body-weight.

Under the second *régime* a complete, a split, or a bivalve plaster is applied immediately after reduction, and the patient is able, almost at once, to get about on crutches. At the end of six to ten weeks a full plaster is removed and physical treatment begun, either with or without some form of ambulatory splint. If a split plaster is employed at the outset, physical treatment can be begun earlier.

The plan of using a fixation splint rather than a full plaster at the outset is said to permit of earlier physical treatment, and swelling and stiffness of the leg and ankle

are thus reduced or avoided. Thus, at a later stage, the period when the patient is walking about but still under physical treatment is shortened. Against this method must be placed the fact that this form of splintage is not so secure in maintaining the fragments in position as when a plaster is employed. There is always the danger of backward angulation occurring when the leg is placed on a back splint, such as Neville's, and, indeed, when it is slung in a Thomas. Massage in the early stage of repair, however gentle, may also cause a similar alteration of position simply from removal of too much of the retentive apparatus.

Against the method of the immediate plaster, it is argued that the injured part is not so readily inspected, decrease of swelling may cause the plaster to be loose in a few days and require replacement, and, with a full plaster, physical treatment cannot be carried out and a considerable degree of oedema may persist for many weeks.

In favour of this method it may be stated that (a) the patient need not be confined to bed for more than a few days, (b) the fragments are held more securely in position, (c) when the time comes for removal of the plaster, the swelling and stiffness, although they have been present for some time, are just as readily dispersed with massage, etc., as at an earlier stage in treatment—and with the reassuring knowledge that such massage is not likely to affect the position of union, which is then considerably consolidated. This last argument does not, of course, apply if a split plaster is employed.

In hospital practice the economic factors (a) of reducing the period of in-patient treatment to a minimum, and (b) the necessity of getting the patient to an ambulatory stage of treatment when he may once more be a wage-earner, often play a large part in influencing the plan of treatment. Whether these factors should be regarded as of major importance is an entirely different problem.

Apart from economic factors, however, there remains the question of the "ideal" treatment. This will, of course, depend primarily on the nature of the practice. If, however, it is decided that the case is not one which calls for treatment by continuous traction, then it would seem that the best method is to effect reduction as soon as possible and to fix the limb immediately in a plaster case divided laterally on both sides. An X-ray is then taken to determine whether the reduction has been effectively carried out. If this is satisfactory, gentle massage may be started almost at once without removing the limb from the posterior half of the plaster. The patient may at this stage walk with crutches without bearing weight on the foot. At a later stage weight may be borne with the aid of some such supporting

apparatus as a Delbet plaster or a moulded leather splint.

Moreover, in the early physical treatment weight may be borne proportionately sooner, as the strength of the muscles has been maintained and they are better able to control the limb.

The various forms of back- and side-splints advocated for use in fractures of this type do not seem to possess any advantages over the divided plaster; they are definitely less efficient in maintaining the position of the fragments and are not made individually for each case.

In the modern treatment of simple fractures of the tibia and fibula and fractures involving the ankle-joint, an early reduction and fixation in some form of plaster splint, followed later by a similar apparatus allowing gradually increased weight-bearing, would seem to give the best results, not only from the point of view of obtaining good functional use of the limb, but also from the economic point of view of both patient and his medical advisers.

My thanks are due to Prof. Gask for his kind permission to publish these cases, and to Mr. J. P. Hosford, under whose direction the treatment of these cases has been carried out, for much helpful advice and criticism.

C. F. WATTS.

RUPTURE OF THE QUADRICEPS EXTENSOR FEMORIS MUSCLE.

RUPTURE of the quadriceps extensor femoris muscles may be (1) unilateral—(a) partial, (b) complete; (2) bilateral—(a) partial; (b) complete.

Unilateral rupture is not uncommon; bilateral rupture is rare. We have been able to find two recorded cases of bilateral rupture. Sigurd Frey (1) cites the following: Male, æt. 60, who jumped from a stage 140 metres high during a dancing festival. He could not stand after this, was unable to walk and experienced sharp pains in both lower extremities. He was treated by bandaging the knee-joints. Eventually he presented himself at the surgical clinic in Königsberg. He was found to have marked muscle atrophy of both thighs. The upper surfaces of both patellæ were easily palpable. There was abnormal mobility of patellæ and active extension of knee-joints was impossible. The left knee-joint could be flexed 100° and the right knee-joint 110° . The patient could stand with extremely flexed knee-joints. Walking was difficult.

X-ray examination showed marked atrophy of femora,

tibiæ and patellæ. In the lateral view of the left knee-joint 8 cm. above the upper border of the patella, two small structureless shadows were seen. In a similar view of the right knee-joint, 1 cm. above the upper border of the patella, a similar shadow was seen in the tendon of the quadriceps extensor femoris.

Electrical reactions of the quadriceps extensor femoris muscles, right and left, were normal.

Albrecht (2) records the case of a man who was hit on the head and stunned. He fell backwards, with point of maximum flexion of body at the knee-joints, rupturing both quadriceps extensor femoris muscles.

Ætiology.—Rupture of the quadriceps extensor femoris muscles may be due to (1) direct violence, (2) indirect violence.

Delbet (3) records an illustration of the former method in which a blow on a man's knee resulted in hæmarthrosis with infiltration of blood in the periarticular tissues and rupture of the quadriceps muscles.

The majority of cases of ruptured quadriceps are due to indirect violence, producing forcible flexion of the knee-joint. The force is in operation for a short time, and it is an interesting question why this jerky force causes rupture of the tendon of the quadriceps and not a fracture of the patella. Is there a predisposing cause present?

Both of the cases we record were healthy men with apparently good musculature, who had enjoyed good health all their lives.

Important predisposing causes are—

(1) *Atrophy of muscles*: (a) Senile atrophy; (b) atrophy from disease; (c) toxic and starvation atrophy; (d) neuropathic atrophy.

(2) *Inflammation of muscles*: (a) Fibrositis; (b) tuberculosis; (c) tertiary syphilis; (d) actinomycosis.

(3) *Trichiniasis*.

(4) *Osteo-arthritis*.

Frankenthal (4) calls attention to diabetes and the uric acid diathesis as important ætiological factors.

In Case No. 1 well-marked osteo-arthritic changes were present in both knee-joints. Unfortunately microscopic examination of the muscles involved was not carried out in our cases. If this were done we might learn some important facts in connection with rupture of muscles.

Symptoms.—Symptoms of shock may be present. There is pain situated over the site of rupture. Patient is unable to extend his leg at the knee-joint to stand or to walk.

Signs.—Signs of shock may be present.

Effusion into the knee-joint may be of a serous or hæmorrhagic character. There may be sanguine crepitations in the periarticular tissues, as in Delbet's case.

A transverse furrow immediately above the upper border of the patella is present. There is abnormal lateral mobility of the patella. Active extension of the knee-joint is impossible in complete rupture. Active flexion of the knee-joint may be limited.

X-ray signs.—Chronic inflammatory changes may be present in the knee-joint, as in Case 1. Frey calls attention to shadows present in the region of the quadriceps extensor muscles, which were apparently areas of calcification in the muscles. Axhausen (5) also records the presence of circular shadows at the lower end of the tendon of the quadriceps.

In Frey's case, the injury being remote, there was marked atrophy of the femur and tibia, and the patella was displaced externally.

Treatment.—In the two cases recorded the lower extremities were immobilized for three and four days respectively on Neville's splint with side-pieces, with continuous pressure applied to the knee-joints.

Operation: Arthrotomy of knee-joint with evacuation of effusion and suture of divided ends of quadriceps muscles with silk. Three to four weeks later, massage for muscles of thigh and leg, and gentle passive movements at the knee-joints.

CASE 1.—A. J.—, male, æt. 66, solicitor's clerk, admitted 14.v.29, complaining of injury to legs.

History of present condition.—14.v.29: Whilst descending stairs carrying heavy legal documents, his feet slipped and both knee-joints were forcibly flexed. Pain was felt above both patellæ. He was unable to assume the erect posture.

Past history.—Always experienced good health except for bronchitis in the winter.

Family history.—Healthy family.

Condition on examination.—Heavy, well-covered man. Suffering from shock.

Eyes normal. Tongue clean and moist. Teeth: Three stumps present. *Fauces and tonsils normal. Heart normal. Lungs:* Emphysema and chronic bronchitis present. *Abdomen:* Irreducible umbilical hernia present; otherwise normal. *Upper extremities normal.*

Lower extremities: Right.—Right knee-joint swollen. Transverse furrow 3 in. long and $\frac{3}{4}$ in. deep, immediately above the superior border of the patella. Abnormal mobility of the patella in the lateral plane. Inability to extend the knee-joint actively.

Left.—Left knee-joint swollen. Transverse furrow 3 in. long and $\frac{3}{4}$ in. deep immediately above the superior border of the patella. Abnormal mobility of the patella in the lateral plane. Inability to extend the knee-joint actively.

Urine.—No abnormal constituents.

X-ray examination.—Knee-joints, right and left: "There are considerable osteo-arthritis changes present in both knee-joints. No evidence of fracture of patellæ."

Diagnosis.—(1) Rupture of quadriceps extensor femoris muscles right, transverse, immediately above the superior border of right patella.

(2) Rupture of quadriceps extensor femoris muscles, left, transverse, immediately above the superior border of left patella.

(3) Osteo-arthritis knee-joint right, chronic.

(4) Osteo-arthritis knee-joint left, chronic.

Complications.—(a) Hamarthrosis knee-joint, right; (b) hamarthrosis knee-joint, left.

Operation.—17.v.29: By Sir Holburt J. Waring, under ethyl chloride-ether anaesthesia.

(1) Arthrotomy of knee-joint, right, through the antero-mesial approach; evacuation of blood-stained fluid from within the knee-joint. Solution of continuity of the quadriceps extensor femoris

muscles present immediately above the superior border of the patella. This involved the aponeurosis and beneath this, muscle-fibres. The ends of the muscles were approximated and held in position by interrupted sutures of No. 2 silk. Parietal wound closed without drainage.

(2) Arthrotomy of knee-joint, left, through the antero-mesial approach; evacuation of blood-stained fluid from within the knee-joint. There was a solution of continuity in the quadriceps extensor muscles immediately above the upper border of the patella; this involved the aponeurosis, and beneath this, muscle-fibres. Identical procedure carried out as on the right side.

The lower extremities were immobilized on Neville's splint with side-pieces, both knee-joints being in position of full extension.

After-treatment.—The wounds healed by first intention.

3.vi.29: Massage for muscles of thighs and legs commenced with gentle passive movements of both knee-joints.

6.vi.29: Patient discharged with both lower extremities in Croft's splints. Flexion at left knee-joint = 15°. Flexion at right knee-joint = 10°. Extension in both knee-joints full. To continue treatment at home.

CASE 2.—A. C.—, æt. 53, of no occupation, admitted 2.iii.29, complaining of injury to right leg.

History of present condition.—2.iii.29: Patient assaulted in the street. He was thrown to the ground, forcible flexion occurring at the right knee-joint. It was stated that the right knee-joint was dislocated, this being reduced by a policeman. Patient unable to walk on right lower extremity.

Past history.—He has always experienced good health.

Family history.—Healthy family.

Condition on examination.—Healthy man. *Eyes normal. Tongue clean and moist. Fauces normal. Heart normal. Lungs normal. Abdomen normal.*

Lower extremities: Left.—Normal.

Right.—Knee-joint swollen. Transverse furrow immediately above the superior border of the patella; this extended from the inner margin of the vastus internus muscle to a point immediately above the outer margin of the patella. Active extension of the knee-joint limited. Lateral mobility of the femur on the tibia present to the extent of 10°.

X-ray examination.—Right knee-joint: the articular surfaces of the femur, tibia and patella are normal. There is no fracture of the patella.

Diagnosis.—(1) Rupture of quadriceps extensor femoris muscles right, transverse, incomplete, immediately above the superior border of the patella.

(2) Rupture of internal lateral ligament of knee-joint, right.

(3) Rupture of external lateral ligament of knee-joint, right.

Complications.—Hamarthrosis, knee-joint, right.

Operation.—8.iii.29: By Sir Holburt J. Waring, under nitrous oxide-oxygen-ether anaesthesia. Arthrotomy of knee-joint, right, through the antero-mesial approach; evacuation of blood-stained fluid. Solution of continuity of the quadriceps extensor femoris muscles found immediately above superior border of the patella extending from its inner aspect to a point immediately above the lateral border of the patella. The ends of the aponeurosis and muscle were approximated and sutured with interrupted sutures of No. 3 silk. Closure of parietal wound without drainage.

Right lower extremity immobilized on Neville's splint, with side-pieces.

After-treatment.—The wound healed by first intention.

19.iii.29: Croft's splint applied from middle of right thigh to the ankle.

13.iv.29: Massage for muscles of right lower extremity commenced. Passive movements begun at right knee-joint.

25.iv.29: Croft's splint removed. Extension of right knee-joint full; flexion of right knee-joint, 160°.

I am indebted to Sir Holburt J. Waring for his kind permission to publish the notes of the two cases.

REFERENCES.

(1) FREY, SIGURD.—*Deutsche Zeitschr. f. Chir.*, No. 9, pp. 284-286.

(2) ALBRECHT.—"Beidersertiger Abriss de Quadriiceps-schne," *Wien. klin. Wochens.*, 1906, No. 22.

(3) DELBET.—*Journ. des Practiciens*, 1924, xxxviii, pp. 180-3.

(4) FRANKENTHAL.—*Münch. med. Wochens.*, 1928, lxxv, No. 1, pp. 563-5.

(5) AXHAUSEN.—*Deutsche Zeitschr. f. Chir.*, Bd. lxxxii.
R. W. RAVEN.

MNEMONICS IN RHYME.

SOME POISONS.

A. PRUSSIC ACID.

"Symptoms come on immediately. The individual may utter a piercing cry, feels giddy and falls down insensible.

"If death be delayed for a few minutes . . . the symptoms are . . . pallor, . . . dilated pupils, laboured and irregular breathing, small and infrequent pulse; . . . there may be convulsions or tetanic spasms." (Robertson.)

The name of prussic acid
To my remembrance calls
The man who gives a gasp or sigh,
Then down insensate falls.

If death be not immediate,
The symptoms to discuss
Are pallor, laboured breathing,
Weak pulse and "tetanus."

B. DIGITALIS.

"Symptoms: nausea, vomiting, purging and abdominal pains . . . headache, giddiness and loss of sight . . . pulse weak, slow and irregular. Death from syncope. Treatment: Emetics, tannin, hypodermic aconitine."

Digitalis in excess,
Pulse is weak and slow,
Belly-ache and tenderness,
Vomiting. B.O.

Aching head and giddiness,
Sudden loss of sight,
Death occurs from syncope;
Treatment: Aconite.

C. PHOSPHORUS.

". . . Earliest signs are garlicky taste in the mouth, and pain in the throat and stomach. Vomited matter . . . luminous in the dark. Great prostration, diarrhoea with bloody stools . . . Usually

. . . remissions for several days, then jaundice . . . hæmorrhages from mucous membranes and under the skin; later coma and convulsions. P.M.: Fatty degeneration of liver, kidneys, etc. . . ."

If you eat yellow phosphorus—several hours from it
You have pains in the stomach and luminous vomit.
A bloody colitis occurs at the end,
And you sail from the world on a bed-pan, my friend!

More often, however, for several days,
The symptoms abate and you go on your ways.
A deepening jaundice now heralds the worst,
With multiple bleedings, prostration and thirst.
Till death comes from coma; its cause? Acidosis.
(The liver and kidneys show fatty necrosis.)

D. OPIUM.

". . . The main differential diagnosis is pontine hæmorrhage."

Now opium, if taken in excess,
Causes excitement first, then drowsiness,
Inaptitude for exercise, then sleep,
Then pin-point pupils with a coma deep—
(The sort of thing an unsuspecting bloke
Might label as an "apoplectic stroke").
With opium, the temperature is low,
In apoplexy it soars up, you know!

F. H. K. G.

THINGS WE THINK.



FROM the art of political propaganda and the art of Epstein let us descend, centring that perseverance residual from our battles with the Philistines on the Art of Being a Patient. The primal difficulty is this of keeping the mind alert—there is so much to think about and so little to think about it that in the comparative quiet of the day we are too inclined to sleep, and only at night, when, without, the quasi-articulate scream of business changes to a deeper, fainter tone, and within, Gargantua sidles round upsetting tin baths, can our thoughts dwell, like Hesiod's, on cosmogony and horticulture.

Marcus Aurelius Antoninus is said to have set down the less meditated of his thoughts in the intervals of public occasions. The possibility that frequent repetition of the same scenes in time invariably suggested the same thoughts perhaps explains why he repeats himself; not that this matters—a great thought has just as little effect said ten times as said once. I propose to say mine once.

Let us take a lesson on keeping the mind alert from men who (though never read) are by the consent of all called great. It is the simple things that interest and employ them. Does not Plato commence the Republic by attempting to define justice? Who can say? We have not read him. Begin then, Sisters of the Sacred well. . . . Begin, and somewhat loudly sweep the string. There is a rosette stamped on a corbel over my head. What can a maker's sign breed, seated in a mind for three weeks? It only shows that our mark put on the material universe may very easily reach posterity without the individuality we wish to preserve becoming any less obscure. The genius may sign his name to his work, or the fool may transcribe it and sign the copy with his own; it does not matter. Posterity will read it just as infrequently, understand it just as inadequately, judge it just as readily, learn from it just as little, and honour the empty name (probably the wrong one) just as foolishly. The wise man would not bother to append his name, or to write for any satisfaction other than his own applause—what would it matter in such a world? Nor could it stave off the ultimate universal stasis forecast by the second law of thermodynamics.

Night has come—now I can think clearly, every wandering of the mind from real to ideal restored by the intensely sane human apparatus around, speaking for itself. I am not in an electrician's laboratory, though lights glitter all about me. I might have dropped amid the glow-worms of *A Midsummer Night's Dream*, but that the screech from the far end of the ward is more piercing than an owl's, and less musical. Why do floorboards creak so? If we knew their idiom they might speak as articulately as we. Till we can prove they can't we must remain in Socratic doubt. The noise of cupboards and screens reminds me more of Dante than of forests.

After so restful a day, who wants to doze at night? Who, indeed, can? We are on duty, praise the gods, and as the door swings open with a gust of pleasant air, the boards give tongue all round with the speed of preparation. Voices murmur—were I less gladly wakeful I might dream I was at the opera, or (but for the lack of coughing) at the Queen's Hall. I suppose it is the vibration of the thousand bated breaths that makes the plaster with which our halls are so grandly adorned shell off at the beginning of a programme, to fall down the throats of so many of the audience, irritating those few unused to calcareous medicines.

It does not do to brood; it's so startling when the stretcher crashes against the door-post; though after the third time it's less worrying, and the other four one scarcely hears. And so morning steals out with silent foot, and the rattle of meat-vans, with tumult of birds

in the eaves and the wheels (very like them, but for the sevenths and elevenths) of the breakfast trolley. Is that rain or frying bacon . . . ? I sleep. Someone pulls my hair and I awake and eat.

I lose count of nights and days.

Senna, least revolting of the devil's brews . . . mild in the mazard, but venomous in the gizzard. I regret not having tasted the tea with milk and sugar. The tincture I recommend you to try before prescribing it, lest you lose patients.

They invite me to sew pillows. Mountains high I am surrounded with unsewn pillows, oozing their unspeakable interiors upon me. Nor have I a genii nor a team of ants to accomplish all in a night. I struggle; I appeal to the gods; sewing with string is unscientific. If only these needles had eyes large enough for anyone but a philosopher to get a camel through! In an evening I complete all.

Not everyone has this curious habit of sleeping in the daytime. My neighbour, who is deaf, snores at night like a Wolf's bottle, bubblingly. But I ponder deeper things. The vague murmurs of inward distress speak, like Claudius's cannon, more or less indirectly to the heavens.

In the next ward a patient yells for help and the police. I, who rarely dream, dream to-night I am a murderer. I have been arrested; I know I shall be convicted; I analyze my chances of escaping death. The analysis does not frighten me; only the doubt of escape makes my bowels sink.

Dawn again shakes out her hair over the eyes of the night:

"Faint stars whose terrible and pale remove
Links icy fingers round the watcher's heart—
These the dread vigillers of deathless night."

Again the doves coo in the immemorial elms, and instead of bees the rumblings of strange contests tremble through the morning air. Never more will I drink the blackish draught called among men HSCo, and unmentionable among the gods, whether or not.

"It fits thee not to be
So cunning in thine own calamity."

As in England the Wars of the Roses faltered and died away, so these intestine broils cease in thirty-six hours or so, and other wonders at last possess my soul. If we believe, with Bertrand Russell, that life is just an excrescence in a universal cycle, why should we not die at once, for is there not in life more pain than pleasure? When under the anæsthetic my blood has ceased thundering in my ears I am more peaceful than when I am asleep. Why should life all labour be? Who can choose between peace and labour? Peace is too insidious for rejection.

We had need be good losers, we mortals. Even the immortals, who keep at least themselves when they lose all besides, may find that little worthless. For us that lose all, is it not indeed pleasant to think that in a hundred years (very probably) or in two hundred years (despite the hopes of Bernard Shaw, for certain) our molecules in death, even as those through life before them, will be, some in that late rock formation, some in the volcanic dust that bears those sunsets, some in an elephant's trunk, maybe, and some in the round-cells of that sarcoma?

Now night follows day, day night, as rapidly as in a time machine, and memory grows vague, even the remembrance of this nurse who is like a Greek epigram—so much in so little space. I had one word more, but a storm leaned out from his throne of thunder and dimmed it in the lightning of an aphorism—one whose sentiment is of the most misleading that I know, because it suggests that beyond human knowledge dwells infinity:

"It is a heart, my beloved,
Where are its shores and its bottom?"*

S.

* Composed just after the successes of May, 1929.

ABERNETHIAN SOCIETY.

On Thursday, June 13th, Prof. Grey Turner gave the Summer Sessional Address on "Well-known Names in Surgery." The address can be best described as an exhibition of the portraits of notable surgeons illustrated by a running commentary.

The lecturer first introduced Sir John Eric Erichsen, of University College Hospital, for whom surgery was more than mere matter for the knife. The lack of anaesthetics used to be one of the main difficulties that confronted the surgeon. Syme, for example, had to perform his famous operation on a professor at his own university without an anaesthetic. Another difficulty was that of procuring bodies for the study of anatomy, in which connection Robert Knox shared in the unpopular notoriety of Burke and Hare:

"Burke's the murderer,
Hare's the thief,
And Knox is the man
Who buys the beef."

Many stories have collected round the personality of Prof. Francis Caird, who combined a wide experience and great teaching power with an unsystematic temperament and a bad memory. At names such as John Hunter, Prof. Turner, overwhelmed by what he might say, said very little. He showed a picture of Hunter's letter to Jenner, in which Hunter replied to a question on the physiology of the hedgehog with the words, "Don't think; why not try the experiment?" The original of the letter has been purchased by Prof. Turner, and is to go to the Royal College of Surgeons.

Lister and Watson Cheyne, Treves, Astley-Cooper and his famous operation on a royal wren, John Hilton, who first stressed the importance of rest in treatment, Walsham, Lockwood, Rickman Godlee, biographer of Lister, Christopher Heath—so the pageant continued.

A pause before the memory of Victor Horsley, who, not completely

satisfied with science and surgery, sought parliamentary fame. Yet he was a beautiful experimenter, whose operations on monkeys had impressed Prof. Turner as some of the finest surgery that he had ever witnessed. A moving account of his death from paratyphoid in Mesopotamia closed the English portion of the address.

A rapid tour of the Continent introduced us to Von Eiselsberg, Wertheim, Lorenz, Czerny—each with a telling comment to accompany his portrait.

Lennander, a Swedish surgeon, is a splendid example of devotion to work. A sufferer all his life from aortic regurgitation, he could only do his morning's work by spending the rest of the day in bed.

Kocher, with over seven thousand goitre operations, and Rovsing, who made a new oesophagus for a child from the skin of the chest-wall, both essentially practitioners, formed an interesting contrast with Ehrlich, whose life was spent in a laboratory six feet by eight, the walls of which were covered with jars of white mice, the floor with books and *débris*, the desk with a little writing space between more piles of books. Bassini, Bastianelli, Putti, Nélaton, who extracted a bullet from Garibaldi, and two pictures remained.

Last but not one Ambroise Paré, who gave expression to the spirit of surgery with the words, "I dress the wound, God cures the patient." And last of all, Abernethy.

Mr. J. E. H. ROBERTS, proposing a vote of thanks, made amusing references to the dual personality of Prof. Grey Turner, which found expression in his name. The vote was seconded by Mr. A. C. BELL, and was carried unanimously.

STUDENTS' UNION.

CRICKET CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. M.C.C.

Played at Winchmore Hill on May 23rd. In this game the Hospital made their best showing of the season against a strong side. Batting first they ran up a total of 257 before declaring with 9 wickets down. A. R. Boney batted very well in making 68, while C. L. Hay-Shunker hit well to make 55 not out. The M.C.C. never looked like getting the runs, and had made 173 for 9 wickets when stumps were drawn. H. L. Hodgkinson took 4 wickets for 46.

ST. BARTHOLOMEW'S HOSPITAL v. METROPOLITAN POLICE.

Played at Thames Ditton on May 25th. In this game the Hospital again batted first, but made a sorry display, being all out for 94. W. M. Capper made 35, and was the only one who seemed able to do anything on a rather bumpy wicket.

Our opponents ran up the big score of 236, and were able to do almost what they liked with the bowling.

ST. BARTHOLOMEW'S HOSPITAL v. MIDDLESEX HOSPITAL.

1st Round, Cup.

Played at Winchmore Hill on May 28th. Our opponents batted first, and although they had 100 runs on the board for 3 wickets, were all out eventually for 166. H. L. Hodgkinson again bowled very well, and took 6 wickets for 35 runs.

The Hospital started very badly, losing their first 2 wickets for 8 runs, but K. W. Mackie and F. E. Wheeler then made a brilliant stand, and knocked off the runs without being separated; K. W. Mackie scored 77, while F. E. Wheeler made 70.

ST. BARTHOLOMEW'S HOSPITAL v. LONDON HOSPITAL.

2nd Round, Cup.

Played at Winchmore Hill on June 19th. This game resulted in a fairly easy win for London, who succeeded in causing a collapse in our first innings, and getting us out for 100. W. M. Capper 34 and G. E. Soden 21 were the only men who played up to form. London, however, could only get 142, as C. L. Hay-Shunker kept a very fine length, and ended up with an analysis of 8 wickets for 43. In the hope of forcing a win on the second innings we went in again, and scored 119 for 9 wickets in just over an hour before declaring. A. R. Boney hit very well in making 48. Our bowling, however, was not deadly enough, and London got the necessary 78 runs for the loss of only 3 wickets.

ST. BARTHOLOMEW'S HOSPITAL v. HERTS WANDERERS.

Played at Micklefield Hall on June 1st. This game ended in an easy victory for our opponents; our batting was bad and we could only make 120, and our opponents scored the necessary runs easily and eventually got well over 200.

PAST v. PRESENT.

Played at Winchmore Hill on June 8th. A very enjoyable game resulted in a victory for the Present by 39 runs. The Present batted first, and A. R. Boney and W. M. Capper put on 114 runs before the first wicket fell, and the side eventually made 207 for 7 wickets declared; W. M. Capper played a fine innings and was unlucky in only being 9 runs short of his hundred. N. E. Cook, for the Past, bowled very well, and took 6 wickets for 51 runs.

The Past, in reply, made an excellent start with N. E. Cook and R. Maingot, and put 96 on the board before Cook left. After this, with the exception of Maingot, who made a magnificent century, there was very little opposition against some excellent bowling by C. L. Hay-Shunker, who took 7 wickets for 56 runs.

ST. BARTHOLOMEW'S HOSPITAL v. HONOR OAK.

Played at Honor Oak on June 22nd. This game ended in a draw in favour of our opponents. At one time it looked as if we were going to dismiss our opponents for a comparatively small score, as 6 wickets went down for only 100 runs. A fine partnership then took place, and Honor Oak finally declared at 202 for 7 wickets.

The Hospital started badly, and lost 2 wickets for 7 runs, but A. R. Boney made a very good 50, and C. L. Hay-Shunker had made 40 not out when the game was left drawn with the score at 149 for 8 wickets. A. R. B.

ST. BARTHOLOMEW'S HOSPITAL v. STREATHAM.

Played at Winchmore Hill on June 29th. This game resulted in a fairly easy victory for Streatham. The Hospital started well and scored 67 before the first wicket fell; after this a collapse set in, and the side were all out for 135. W. M. Capper played a very good innings of 61. Our opponents obtained the runs for the loss of only 4 wickets.

ST. BARTHOLOMEW'S HOSPITAL v. CHORLEY WOOD.

Played at Chorley on July 6th. This game ended in a tame draw. Chorley Wood batted first, and between stoppages for rain scored 195 for 7 before declaring, leaving the Hospital only one and a half hours to get the runs. This was well-nigh impossible, and the final score was 98 for 4 wickets. W. M. Capper again did well in scoring 49.

ST. BARTHOLOMEW'S HOSPITAL v. ST. ANN'S.

Played at Virginia Water on July 10th. A very close game ended in a victory for the Hospital, who batted first and scored 208; nearly everyone made runs, the top scorers being C. L. Hay-Shunker 43 and G. E. Loden 40. Our opponents did not quite succeed in getting the runs, and were all out for 194. C. L. Hay-Shunker took 7 wickets for 83.

ST. BARTHOLOMEW'S HOSPITAL v. R.A.F., HALTON.

The last match, July 20th, ended in an easy victory for the Hospital, who scored 251, and dismissed their opponents for 137. A. R. Boney and F. E. Wheeler batted very well and put on nearly 100 runs for the second wicket. H. L. Hodgkinson took 6 wickets for 58.

SUMMARY.

The results for the season 1929 were as follows: Matches won, 7; lost, 9; drawn, 3.

Under the inspiring leadership of H. L. Hodgkinson the team always seemed as if they might have done even better than they did. The chief weakness lay in the batting, which was liable to sudden and inexplicable collapses. A. R. Boney, W. M. Capper, G. E. Soden and C. L. Hay-Shunker made quite a number of runs, and F. E. Wheeler played two very good innings, but runs on several

occasions were not forthcoming when they were most needed. K. W. Mackie, when he was able to turn out, greatly strengthened the batting, and made a good many runs, and it is a great loss to the Club that he will be unable to help us any more. H. L. Hodgkinson and C. L. Hay-Shunker bore the brunt of the bowling, and on occasions bowled extraordinarily well; our change bowlers unfortunately were rather weak.

On the whole we may look on 1929 as quite a satisfactory season, and have every reason to expect even better results in 1930.

HOCKEY CLUB.

ANNUAL GENERAL MEETING.

The Annual General Meeting of the Hockey Club was held on July 9th, 1929, with Dr. Morley Fletcher in the chair.

Dr. Morley Fletcher declined re-election as President on account of his retirement from the active staff.

Dr. Gow was elected President, Mr. JUST and Dr. GEOFFREY EVANS Vice-Presidents.

Captain, 1st XI: P. M. WRIGHT.

Hon. Sec., 1st XI: H. L. HODGKINSON.

Captain, 2nd XI: A. D. ILIFF.

Hon. Sec., 2nd XI: H. D. GALE.

Captain, 3rd XI: T. O. MASON.

Hon. Sec., 3rd XI: R. F. CLARKE.

Committee: W. F. CHURCH and R. S. FORDHAM.

Match Secretary: P. M. WRIGHT.

A vote of thanks was proposed to Dr. Morley Fletcher for the keen interest he has shown in the activities of the Club during his long term of office.

The following were awarded Hockey Honours for the season 1928-29: W. F. Church, K. W. D. Hartley, M. S. Fordham, F. C. H. White, A. G. Williams, R. H. Francis, E. J. Neill, J. W. C. Symonds, F. H. McCay, P. M. Wright, H. L. Hodgkinson. H. L. H.

CORRESPONDENCE.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I have just read "Medical Notes on Influenza" by Sir Thomas Horder, in your May number.

It is clear and instructive, but when he comes to treatment I cannot agree with him that drugs are to be cut out altogether. We have had a good deal of experience here with that malady, both epidemic and sporadic; eventually I arrived at a combination of aspirin and phenalgin, and when pain and restlessness are present a small quantity of heroin is added. On my suggestion Oppenheimer made up bi-palatinoids containing aspirin and phenalgin aa gr. iiss, heroin gr. $\frac{3}{16}$. Made up in that way the combination does not deteriorate.

In the great majority of cases two palatinoids every 4 hours will beat an attack of 'flu in 24 hours. It sets up violent perspiration. The sooner the treatment is started the better. It is also an excellent remedy for acute attacks of gout.

You need not necessarily publish these remarks, but give the treatment a trial.

Possibly you might like to know how to beat measles in 2 days; if so let me know. I spent a fortnight in bed at Bart.'s in 1883, and had cough and disability for two weeks longer—now I think nothing of it.

Yours sincerely,

Johannesburg;
June, 1929.

G. E. MURRAY.

ACKNOWLEDGMENTS.

British Journal of Nursing—British Journal of Venereal Diseases—L'Echo Médicale du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East Africa Medical Journal—King's College Hospital Gazette—Leprosy Notes—Long Island Medical Journal—The Magazine of the London Royal Free Hospital School of Medicine for Women—The Medical Review—The Nursing Times—Post-Graduate Medical Journal—Revue de Médecine—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Speculum.

REVIEWS.

ON NEPHRITIS. By A. CECIL ALPORT, M.D. With an Introduction by Prof. LANGMEAD. (London: William Heinemann, Ltd., 1929.) Pp. xiii + 175. Price 7s. 6d.

The author of this book is to be congratulated on having compressed a very considerable amount of information into a small space, and on having produced a readable survey of a difficult subject. We are glad to see that he takes his stand against the too frequent tendency of the clinician to desert the bedside for the laboratory—a tendency which is liable to produce a poor clinician and a still worse laboratory worker.

Such books must, of necessity, include a statement of the views, on numerous matters, of those who have laboured in obscure corners of the field. For the protection of those of us who dwell in the half-lights of knowledge it is of great value to have the considered opinion on these views of such a "general specialist on the subject"—to apply a term recently used in our hearing by a layman—as the author of this book would, we imagine, not be averse to being considered. He has given his opinions, but we suggest that in the next edition he should give more—particularly in regard to his experience with the various chemical methods mentioned. Meanwhile we are grateful for his warning that although the treatment of acute nephritis with large doses of alkalis may give scope for a display of vicarious heroism by the expert, who must battle on, undaunted by the menace of tetany, oedema and death, it is not to be recommended for general practice.

The book is concluded by a selection of useful prescriptions, charts of the salt concentration test, and an extensive list of references. In this list we notice one publication which is, apparently, in the Magyar tongue. Although the inclusion of such an item speaks highly of Dr. Alport's linguistic attainments, it seems unlikely that the work in question will receive that universal attention to which, on its merits, it is doubtless entitled.

HEART DISEASE IN CHILDHOOD. By H. B. RUSSELL, M.D., M.R.C.P. and C. K. J. HAMILTON, B.M., M.R.C.P. (London: Constable & Co., 1929.) Pp. 104. Price 7s. 6d.

This book is a useful and worthy addition to the series of Modern Medical Monographs, which is edited by Dr. Hugh MacLean.

During the last few years a great deal of attention has been paid to the crippling effects of rheumatic heart disease in children. In order that disablement may be reduced as far as our present knowledge will permit, it is essential that medical men, and general practitioners in particular, should have a clear conception of the matter. The authors of this small volume have condensed the modern teaching on the subject and present it in a short, concise, yet thoroughly interesting and readable manner. The section dealing with the development of mitral stenosis and the chapter on the treatment of the rheumatic child are particularly clear and helpful.

While the major portion of this book naturally deals with rheumatism and its effect on the heart, it also contains good chapters on cardiac irregularities, congenital heart disease, and the electro-cardiograph.

SOME PRINCIPLES OF MINOR SURGERY. By ZACHARY COPE, M.S., M.D., F.R.C.S. (Humphrey Milford, Oxford University Press, 1929.) Pp. 159. Price 10s. 6d.

Under this modest title the author has collected eight thoughtful and thought-provoking studies in minor surgery. Infections of the hand, common sprains, ambulatory fractures, acute retention of urine—such diverse subjects come under review. Yet through the woven pattern of the book there runs a common thread—think, be precise in observation, be reasonable in treatment. The lesson of such principles can never be learned too well; their application requires emphasis not so much in major surgery where the surgeon is called upon to grapple with a worthy problem, as in those minor ailments, which arouse little sympathy and less interest. "Small showers last long, but sudden storms are short": a patient may lose more time and be more incommenced with a "septic hand" than with an acute appendix.

The first essay, on the use and abuse of antiseptics, puts in a few clear sentences illustrated by some quotations from Lister the present position between aseptic and antiseptic surgery. It can be particularly recommended to those whose critical faculties emerge slightly dazed from the routine of a first six months of surgery, and

for whom what is important has become confounded with much that is not.

Mr. Cope is already a medical best-seller. This is another of his books for which it is safe to prophesy a wide public.

HANDBOOK OF ANÆSTHETICS. By J. STUART ROSS, M.B., F.R.C.S., and H. P. FAIRLIE, M.D. Third edition. (Edinburgh: E. & S. Livingstone, 1929.) Price 8s. 6d.

In the latest edition the authors continue their original plan of dealing chiefly with the practical side of the subject. The theoretical side is not neglected, but stated in a readable and interesting manner.

The chapters on the "Causes and Treatment of Asphyxia" and "Accidents and Sequelæ" are both practical and good, whilst that on the "Choice of Anæsthetic" is most useful, dealing, as it does, with the subject from the point of view of the patient's condition and the requirements of the surgeon.

Nitrous oxide and oxygen anæsthesia is dealt with in detail, but only two standard machines are described—Boyle's and McKesson's—in place of the many types in the last edition.

The chapter on the use of ether includes a clear and concise description of a kind of induction by the open method which should be a boon to all those starting to give anæsthetics in general practice with the proverbial two bottles and a mask.

The advantages and disadvantages of chloroform are stated clearly, and include a few words of warning from Prof. Leonard Hill to would-be users of this drug.

A brief chapter on endotracheal anæsthesia together with chapters on ethylene, spinal and local anæsthesia bring the work up to date.

A practical book on an essentially practical subject.

CATALOGUE OF LEWIS'S MEDICAL AND SCIENTIFIC CIRCULATING LIBRARY. Part I: Authors and Titles. Part II: Classified Index of subjects, with Names of Authors who have written upon them. Revised to the end of 1927. (H. K. Lewis & Co., Ltd., 1928.) Pp. 576. Price 15s. net. To subscribers, 7s. 6d. net.

"I do not know any reading more easy, more fascinating, more delightful than that of a catalogue," said the immortal bibliophile Sylvestre Bonnard. Though not a catalogue of rare manuscripts, but a simple list of medical and scientific works, the daily bread of professional learning, this book has its fascination and, what will be more fully appreciated, its practical value. Is there anything you want to know? Here are all authors, from Aaron (C. D.) to Zumbusch (L. v.), and all subjects from Abattoir to Zoology (Marine).

Everyone knows Lewis's, and nearly everyone belongs. The student, young in years and by nature impecunious, may find there the books from which to sip the divine nectar of learning, and for a sum paltry in comparison with the benefits he gains. The busy practitioner, anxious to profit by the latest doctrine, may send hurriedly for the Library's aid. This catalogue will be of great use to subscribers. Its preparation must have meant much labour, and is a further proof of that desire to be helpful which has characterized Lewis's eighty years of service to the medical profession.

RECENT BOOKS AND PAPERS BY
ST. BARTHOLOMEW'S MEN.

BARRIS, J. D., M.B., F.R.C.S. "Induction of Labour for Disproportion." *Journal Obstetrics and Gynaecology British Empire*, Summer No., 1929.

BERTWISTLE, A. P., M.B., Ch.B., F.R.C.S.(Edin.). "Fracture of the Patella." *Lancet*, June 29th, 1929.

CHESTER-WILLIAMS, F. E., M.R.C.S. "New Inventions: Radium Forceps." *Lancet*, June 29th, 1929.

DAVIES, IVOR J., M.D., F.R.C.P. "Brucella Abortus Infection in Man." *British Medical Journal*, July 6th, 1929.

DUNDAS-GRANT, Sir JAMES, K.B.E., M.D., "The Nasal Factor in the Treatment of Asthma." *Practitioner*, July, 1929.

FLETCHER, Sir WALTER, K.B.E., F.R.S., M.D., F.R.C.P. "Thoughts on University College." An Address delivered to the Assembly of Faculties of the College on July 4th. *Lancet*, July 13th, 1929.

- MORLOCK, H. V., M.C., M.D., M.R.C.P. "Development of Pulmonary Tuberculosis." *Lancet*, July 13th, 1929.
- PARAMORE, R. H., M.D., F.R.C.S. "Eclampsia and its Renal Lesion." *Journal Obstetrics and Gynaecology British Empire*, Summer No., 1929.
- PATERSON, HERBERT J., C.B.E., M.Ch., M.D., F.R.C.S. *Indigestion: Its Differential Diagnosis and Treatment*. London: H. K. Lewis & Co., 1929.
- PICTON, LIONEL JAS., O.B.E., M.B., B.Ch. "On the Origins and Treatment of Dyspepsia." *British Medical Journal*, June 29th, 1929.
- ROLLESTON, SIR HUMPHRY, Bart., G.C.V.O., K.C.B., M.D., D.C.L., Hon. D.Sc.(Oxon.), LL.D., F.R.C.P. "Medical Clubs and Societies." MacAlister Lecture. *British Medical Journal*, June 29th, 1929.
- "Introduction to Special Asthma Number." *Practitioner*, July, 1929.
- SHARP, B. BUCKLEY, M.D., B.S., M.R.C.P. (D. NABARRO, M.D., F.R.C.P. and B.B.S.). "Vulvo-Vaginitis." Garrod, Batten, Thursfield and Paterson's *Diseases of Children*, 2nd edit., 1929.
- SPARKS, J. V., D.M.R.E., M.R.C.S. "The Difficulties of Comparative Radiography of the Chest." *British Journal of Radiology*, July, 1929.
- WEBER, F. PARKES, M.D., F.R.C.P. "Symphysis of the Spleen with the Liver: Spontaneous Rupture of the Right Ventricle and Syphilitic Aortitis." *British Medical Journal*, July 6th, 1929.

EXAMINATIONS, ETC.

University of Cambridge.

First Examination for Medical and Surgical Degrees, Easter Term, 1929.

- Part I. Chemistry.*—Chopra, I. C., Green, W. O., Jeremy, W. H. R.
- Part II. Mechanics.*—Brennan, E. B., Chopra, I. C., Evans, J., Gibson, R. G., Green, W. O., Hutt, C. W., Knight, W. C.
- Part III. Physics.*—Chopra, I. C., Hepworth, A. J., Hunt, R. S., Jeremy, W. H. R., Warren, W.
- Part IV. Elementary Biology.*—Chopra, I. C., Green, W. O., Jeremy, W. H. R., Warren, W.

Second Examination for Medical and Surgical Degrees, Easter Term, 1929.

- Part II. Human Anatomy and Physiology.*—Fulton, I. N., Jones, J. D. M., Lown, J. F., Powell, J. D., Scott, J. L. S., Summerhill, J. H. E., Wenger, R. A. L.

Third Examination for Medical and Surgical Degrees, Easter Term, 1929.

- Part I. Surgery, Midwifery and Gynaecology.*—Bradshaw, G. H., Hutchinson, H. P., MacVicker, G. C. C., Sugden, E. C., Winterton, W. R.
- Part II. Principles and Practice of Physic, Pathology and Pharmacology.*—McCay, F. H., Oakley, W. G., Varley, J. F., Wood, F. W. J.

CHANGES OF ADDRESS.

- ACRES, G. C. JOHNSTON, Leasholme, Waldegrave Road, Twickenham.
- BELLERBY, O. H., Queen Charlotte's Maternity Hospital, 5, Cosway Street, W. I.
- CLARK, FRANCIS, "Rylstone," Hunton Bridge, King's Langley, Herts.
- EVANS, E. S., 8, Havelock Road, Southampton.
- HISCOCKS, H. F., 18, Royal Terrace, Southend-on-Sea, Essex. (Tel. Southend-on-Sea 2014.)
- NOBLE, J. A., Peter's Point, 54, Charminster Avenue, Bournemouth.
- ROXBURGH, G. P., 57, Marine Avenue, Hove, Sussex.

APPOINTMENTS.

- GILDING, H. P., B.M.(Oxon.), appointed Lecturer and Demonstrator of Physiology at University College, W.C. 1.
- ROBERTS, J. E. H., M.B., B.S.(Lond.), F.R.C.S., appointed Consulting Surgeon to the Sanatoria of the Metropolitan Asylums Board.

BIRTHS.

- BROCKMAN.—On July 15th, 1929, at 24, Kenwood Park Road, Sheffield, to Estelle, wife of R. St. Leger Brockman, F.R.C.S.—a daughter.
- CROSS.—On June 30th, 1929, at Villa Alberte, Roquebrune, Cap Martin, to Joy (née Kennerley-Rumford), wife of Major C. H. Cross—a son.
- DOYLE.—On June 6th, 1929, at The Square, Fakenham, Norfolk, to Gladys Theodora, wife of Dr. J. L. Cyril Doyle—a daughter.
- FRANKLIN.—On July 15th, 1929, at 25, Banbury Road, Oxford, to Ethel, wife of Dr. K. J. Franklin—a daughter (Elizabeth Angela).
- GRIFFITH.—On July 4th, 1929, at Roydon, Torquay, to Harold Kinder and Helena Griffith—a son.
- KITCAT.—On July 16th, 1929, to Mary (née Sellors), wife of Dr. C. de Winton Kitcat, St. Leonards-on-Sea—a son.
- RICHARDSON.—On July 15th, 1929, at 45, Morrab Road, Penzance, to Marjorie (née Pettit), wife of G. B. Richardson, F.R.C.S.—a daughter.
- THOMSON.—On June 28th, 1929, at Lavington, Barnet, Herts, to Doris, wife of Dr. N. Gray Thomson—the gift of a daughter.

MARRIAGES.

- BRADLEY—THOMPSON.—On July 16th, 1929, at St. Germain's Church, Edgbaston, Edwin John Bradley, M.C., M.D.(Camb.), F.R.C.S.(Ed.), son of Mr. and Mrs. Edwin Bradley, of Dover, to Norah Dorothy, daughter of the late Mr. H. H. Thompson and Mrs. Thompson, of Edgbaston.
- CORFE—MUNNS.—On July 6th, 1929, at All Saints' Church, Kingston-on-Thames, Frederick Robert, eldest son of Mr. and Mrs. A. Frederick Corfe, of "Wayside," Maidstone, Kent, to Dorothy Isabel, only daughter of Mr. and Mrs. H. R. Munns, "The Pantiles," Uxbridge Road, Kingston-on-Thames.
- GONIN—LAW.—On July 12th, 1929, at St. Columba's (Church of Scotland), by the Rev. Archibald Fleming, D.D., assisted by the Rev. Henry Atkinson, Mervyn Willett, only son of Mr. and Mrs. Willett Gonin, of Haywards Heath, to Ohna Marguerite, only daughter of Mr. and Mrs. David Law, of 16, North Hill, Highgate, N.
- GOW—RANNIE.—On July 1st, 1929, at the Church of St. Bartholomew the Great, by Prebendary W. Budgen (uncle of the bridegroom), assisted by Canon E. S. Savage, Alexander Edward Gow to Aileen Gordon Rannie.
- WOOD—WETENHALL.—On July 13th, 1929, at All Saints' Church, West Dulwich, by the Rev. G. S. Day, M.A., assisted by the Rev. A. Gordon Ward, M.A., Ronald Walter, only son of Walter J. Wood and the late Mrs. Wood, of Wembley Park, to Alice Joyce, younger daughter of Mrs. Wetenhall and the late J. H. Wetenhall, of 3, Alieyn Park, Dulwich.

DEATHS.

- KEITH.—On June 8th, 1929, at Rockford, Illinois, Darwin Mills Keith, M.R.C.S., L.R.C.P., aged 62.
- MOXHAM.—On June 27th, 1929, at Aldborough, Marcus Camplin Moxham, M.R.C.S., L.R.C.P., L.S.A.
- PARKER.—On July 15th, 1929, at Thames View Cottage, Flackwell Heath, Bucks, George Dines Parker, M.R.C.S., L.R.C.P., M.B. (Lond.), aged 64.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.